Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Group Long Term Care Insurance Application
Evidence of Insurability

**PLEASE OPEN FORM COMPLETELY BEFORE WRITING ON EACH PAGE.
FILL IN ALL SECTIONS. PROCESSING MAY BE DELAYED IF INCOMPLETE.**

**Applicant, answer all questions and sign.
Alterations to the pre-printed text will void this Evidence of Insurability.**

SEND ORIGINAL TO: **Unum Life Insurance Company of America
Attn: Long Term Care Underwriting
2211 Congress Street, Portland, ME 04122-2295**

SEND ORIGINAL TO UNUM LIFE INSURANCE COMPANY OF AMERICA. KEEP CARBON COPY FOR YOUR RECORDS.

Policyholder's (i.e. association, employer) Name	Policyholder's ID or Policy No.

I. General Information

Your Name:

(First) (Initial) (Last)

Complete Address:

(Street/PO Box) (City) (State) (Zip Code)

Social Security Number:	Date of Birth: Month Day Year __ __ / __ __ / __ __ __ __	Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Are you presently working? ❑ Yes ❑ No If yes, list occupation:	Daytime Telephone Number: ( )

Your Height:	Your Weight:	Have you used tobacco products in the last 12 months (chew or smoke - circle applicable activity)? ❑ Yes ❑ No

Have you had any change in weight in the last 12 months? ❑ Yes ❑ No	❑ Gain _____lbs. ❑ Loss _____lbs.	Reason for Weight Change:

Primary Physician's Name:	Date of Last Physical Exam: Month Day Year __ __ / __ __ / __ __ __ __
Primary Physician's Address:	Primary Physician's Telephone Number: ( )

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this insurance with and without the Uncapped Compound Growth Inflation Protection Option and I Accept ❑ / Reject ❑ this option.

I have reviewed the Nonforfeiture Benefit in the Outline of Coverage. I Accept ❑ / Reject ❑ this option.

II. Insurability Profile

A. ❑ Yes ❑ No	Do you use mechanical devices, such as: a wheelchair, walker, quad cane, crutches, hospital bed, dialysis machine, oxygen, or stairlift?
B. ❑ Yes ❑ No	Do you currently need or receive help in doing any of the following: bathing; eating; dressing; toileting; transferring; maintaining continence?
C. ❑ Yes ❑ No	Do you currently have, or within the last seven (7) years, have you had a diagnosis for: Alzheimer's disease, dementia, loss of memory, or organic brain syndrome?
D. ❑ Yes ❑ No	Do you currently have, or within the last seven (7) years, have had a diagnosis for: Multiple Sclerosis, muscular dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease?
E. ❑ Yes ❑ No	Within the last seven (7) years, have you been diagnosed and/or treated by a member of the medical profession for HIV+?
F. ❑ Yes ❑ No	Within the last seven (7) years, have you developed symptoms of the disease AIDS?
G. ❑ Yes ❑ No	Within the last seven (7) years, have you been diagnosed and/or treated by a member of the medical profession for AIDS?

III. Medical Profile

A. Do you have symptoms of, or within the last seven (7) years, have you received medical advice, been diagnosed, treated or consulted with a member of the medical profession or other health care professional for any of the following conditions? **Please circle condition(s) for all "YES" answers.**

❑ Yes ❑ No	1. High blood pressure, irregular heart beat, atrial fibrillation, coronary artery disease, or other diseases or disorders of the heart or circulatory system, blood or blood vessels.
❑ Yes ❑ No	2. Polyp, benign tumor, leukemia, lymphoma, cancer, melanoma, or a disorder of the immune system.
❑ Yes ❑ No	3. Diabetes, thyroid problems, or any glandular disease or disorder.
❑ Yes ❑ No	4. Intestines, liver or disease or disorder of the stomach or digestive system.

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❑ Yes ❑ No	5. Bowel, rectum, kidney, bladder, prostate, urinary tract, or reproductive system.
❑ Yes ❑ No	6. Mental disorder, depression, bulimia, anorexia or other eating disorder, alcohol abuse, drug addiction, or any psychological or emotional condition or disorder; or been advised to limit, reduce or discontinue the use of alcohol; been arrested in connection with use of alcohol or drugs; or been advised to seek or receive counseling for alcoholism or drug abuse.
❑ Yes ❑ No	7. Arthritis, osteoporosis, any chronic pain condition, or any other disease or disorder of the back, spine, joints, muscles or neck.
❑ Yes ❑ No	8. Lung disorder, shortness of breath, or any disease or disorder of the respiratory system.
❑ Yes ❑ No	9. Falls, dizziness, imbalance, or any disease or disorder of the eyes or ears.
❑ Yes ❑ No	10. Seizures, tremors, stroke, transient ischemic attack (TIA), paralysis or any other disease or disorder of the brain or nervous system.
❑ Yes ❑ No	11. Any other conditions or diseases not mentioned above? Please describe in this area _____ _____ _____

If you answered "Yes" to any of the questions in section IIIA, please indicate question number from IIIA and provide full details on the condition, treatment dates and the name, address and telephone number of your medical advisor.

Ques No.	Date of Last Visit Mth/ Day/ Year	Reason/ Name of Condition	Treatment Given	Medical Advisor's Full Name, Address & Telephone Number
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B. ❑ Yes ❑ No	Have you taken any prescription/non-prescription medications in the past 24 months, including all prescription/non-prescription medications you are currently taking? Please list the medication and details.

Date Taken Mth/ Day/ Year	Name of Medication	Dosage/ Frequency	Reason/Name of Condition	Prescribing Physician
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C. ❑ Yes ❑ No	Have you been hospitalized, been advised or had surgery, medical care, EKG, x-ray, diagnostic test or been confined to any facility in the last seven (7) years? If yes, provide details

Test(s) Performed	Date Mth/ Day/ Year	Reason	Results	Name, Address & Telephone Number of Medical Advisor Requesting Test(s)
	_ _/_ _/_ _ _ _			
	_ _/_ _/_ _ _ _			
	_ _/_ _/_ _ _ _			

D. ❑ Yes ❑ No	Do you live alone? If no, who lives with you? _____
E. ❑ Yes ❑ No	Do you drive? If no, why? _____
F. Please describe your daily routine, i.e. work, exercise, travel, socializing, physical/recreational activities, etc.: _____ _____	

IV — Insurance History

A. ❑ Yes ❑ No	Are you covered by Medicaid? (If yes, details.) _____ _____
B. ❑ Yes ❑ No	Are you receiving any disability benefits? (If yes, provide details or health condition.) _____ _____
C. ❑ Yes ❑ No	Have you had another long-term care insurance policy or certificate in force during the last 12 months? If yes — Name of Company: _____ If it lapsed, when did it lapse? _ _/_ _/_ _ _ _
D. ❑ Yes ❑ No	Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract?) If yes — Name of Company: Policy Number: Type and Amount of Benefits: _____ _____ _____
E. ❑ Yes ❑ No	Do you intend to replace any of your long term care, medical or health coverage with the coverage applied for? If yes — Name of Company: Policy Number: Type and Amount of Benefits: _____ _____ _____
F. ❑ Yes ❑ No	Within the last seven (7) years, have you been denied coverage for medical insurance, disability insurance, long-term care insurance, nursing home insurance, life insurance or received substandard coverage? If yes – Name of Company:_____ Coverage:_____ Date Denied: (Mth/ Day/ Yr) _ _/_ _/_ _ _ _ Reason for Denial? _____
G. ❑ Yes ❑ No	Have you signed a Power of Attorney authorizing another individual to manage your personal affairs? If yes, why? _____

V. Authorization to Obtain Information

I authorize any **person or organization** to give Unum Life Insurance Company of America, or its subsidiaries or representatives, if any, any of the following:

- information about any injury or illness I have or I have had, including mental illness or drug or alcohol abuse;
- information about my medical history including any consultations, prescriptions, treatments or benefits;
- copies of all records that may be requested concerning me and
- non-medical information about me.

The term **person or organization**, which is used above, means any of the following:

- a physician or medical practitioner
- any insurance support or reporting agency
- a hospital, clinic or other medical treatment facility
- any pharmacy
- any government agency
- any insurance or reinsurance company
- any employer

I understand that the information obtained by use of this authorization will be used by Unum Life Insurance Company of America to determine eligibility for insurance and eligibility for benefits. Unum Life Insurance Company of America will not release any of the obtained information to any other person or organization except:

- reinsuring companies; or
- persons or organizations performing business or legal services in connection with my application or claim as may be otherwise lawfully required or, as I may further authorize.

I understand that this authorization shall be valid for two and a half years from the date shown on the application and that a photographic copy of this authorization shall be as valid as the original.

VI. Applicant's Signature

The statements I have made on this application are true to the best of my knowledge and belief.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, UNUM LIFE INSURANCE COMPANY OF AMERICA MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR INSURANCE. I HAVE READ AND UNDERSTAND THE AUTHORIZATION ABOVE AND THE DISCLOSURE STATEMENT ON THE NEXT PAGE OF THIS APPLICATION.

Notice: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be prosecuted for insurance fraud.

X_____ Date: __ __/__ __/ __ __ __ __

Applicant's Signature Mth Day Year

_____

Signed at (City/State)

Disclosure

Notice of Insurance Information Practices

Thank you for applying to Unum Life Insurance Company of America. As part of our normal underwriting procedure, we need to obtain information to determine an Applicant's eligibility for insurance. Much of that information will come from you; however, we often obtain additional information or verify information through other sources.

Collection

Your application, including the medical questionnaire and any exams, is our main source of information. However, Unum Life Insurance Company of America may need to obtain additional information from other sources about your age, physical condition, occupation, other insurance coverage, health history, avocations, general reputation and lifestyle.

Unum Life Insurance Company of America may obtain this information from physicians, hospitals, clinics or other medical professionals or medical care facilities. We may collect information in person, by telephone, or by exchanges of correspondence.

Disclosures

Unum Life Insurance Company of America will not disclose to others the information, which we obtain about you without your prior authorization except as necessary to conduct our business (and then only if disclosure is permitted by law).

For example, if necessary, Unum Life Insurance Company of America may disclose information to:
- persons and organizations that perform insurance, or business or professional services for us;
- other insurance companies to which you have applied for coverage or benefits;
- insurance companies, agents, or insurance support organizations to help detect or prevent insurance fraud or misrepresentation;
- a medical professional or facility so it can properly notify you of a medical condition of which you may not be aware;
- our reinsurers;
- insurance departments or commissions in connection with audits or examinations of our company;
- law enforcement agencies to help prevent or prosecute fraud or to alert them that unlawful activity may have occurred; or
- a research or actuarial organization.

These are disclosures that Unum Life Insurance Company of America is permitted to make- not disclosures that we make often. In fact most disclosures made by us are to identify you for collection of information, for reinsurance or other services, or to help detect or prevent fraud and misrepresentation.

Access to Information
You have a right to recorded personal information about you, which is in Unum Life Insurance Company of America's files and is reasonably locatable. To ensure security of information in our files, we will require positive identification before we allow access to that information. To obtain access to recorded personal information about you, send a signed, written request to the address on the front page of this Application. Give your full name, address, telephone number, and policy number if a policy has been issued.

Within 30 business days after we receive your request, we will inform you of the nature and substance of the information in our files, which is reasonably locatable and retrievable. We will also tell you to whom we have disclosed this information within the last two years. If you wish we can show you the information at our Home Office or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional chosen by you. You may have to pay a reasonable charge to cover the cost of the copies.

Correction of Information
If you believe any of Unum Life Insurance Company of America's information is not correct, please notify us and explain why you believe it is inaccurate or incomplete. We will review it. If we agree with you, we will correct the information and notify any person designated by you to whom we have disclosed the information within the preceding two years.

If we disagree with you, we will tell you that we will not make the requested change. Then you may submit to us information and your reasons for disagreeing with our decision not to change the information. We will then furnish your statement to any person designated by you to whom we disclosed the information in the prior two years and to anyone else who may receive the information from us in the future.

Applicant should retain a copy of this page for their records.

UnumProvident

Printed Name of Applicant: _____
(First Name) (MI) (Last Name)

Social Security Number: _____

Policy Number: _____

NOTE: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or process your application. Please sign and return this authorization to: Group Long Term Care Underwriting, 2211 Congress Street, Portland, ME 04122.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory or other medically related facility or service; insurance company; insurance service provider; third party administrator; producer; and employer that has information about my health; employment; or other insurance coverage, claims and benefits to disclose any and all of this information to persons who evaluate and process applications for UnumProvident Corporation, Unum Life Insurance Company of America, and duly authorized representatives ("UnumProvident"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and processing my application for coverage. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two (2) years from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or process my application and this may be the basis for denying my application. I may revoke this authorization by sending written notice to: Group Long Term Care Underwriting, 2211 Congress Street, Portland, ME 04122.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or process my application and this may be the basis for denying my application.

_____ _____
(Applicant Signature) (Date Signed)

I, _____, signed on behalf of the applicant as the applicant's Personal Representative. Please circle the type of Personal Representative: Power of Attorney Designee, Guardian, Conservator; and attach a copy of the document granting authority.

Unum Life Insurance Company of America
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